A quick note from Dr. AvatarNirvana Perez,

Congratulations! You are making your health a priority, looking for answers and making a choice to put yourself first. Making your health a priority takes courage and action and you are demonstrating both. Whatever reason brings you to us today, we're glad you're here. If every journey begins with one step, this is your first step towards actualizing a stronger, healthier, resilient, more vibrant you. Smart choice. You've got questions. We've got answers. There's a lot of parroted *mis*-information about bodies and how they function. This *mis*-information, regardless of how ingrained in our popular culture or good intentioned as it may be, are lies easily dispelled with a little common sense and deductive reasoning.

First, bodies are very complicated, however, the basic principles that govern our bodies are really simple. Second, there is no “magic pill” or bed or spray that will immediately cure you of anything and everything so you can continue the behaviors and practices that poisoned your body in the first place. Anyone who tells you differently is trying to sell you something. I'm not trying to sell you anything. Products I mention or recommend are products that I personally use or have personally used in the past when my body needs extra support. Whether you buy the brand I use or another brand makes zero difference to me and if you find a brand you think is better feel free to send me an email. I love trying new things as long as they meet Foodology requirements.

Third, detoxing is not something you do once a year or twice a year for a couple days or a week. Because we are constantly being bombarded with toxins in our food, our water, our skies, our pHARMaceuticals, our clothes, our homes and our technologies, detoxing and immunological support are daily practices. As our environments, what we grow, what we eat and our bodies get cleaner we need less support outside of what we eat, how we prepare food and how we combine foods. Fourth, we don't heal you with a theatrical performance or *cure* you with some *Emperor's New Clothes* narrative. Nobody can *cure* you except for you. You are the *cure* and your body is a miracle.

Even if I could simply snap my fingers, wiggle my nose or concentrate my manifestations to *cure* you, I would not. Your choices are why you are in the health you are in and it is your choices that have the power to change your health. If I just snap my fingers, what's to stop you from making the same choices that got you here in the first place?

We have ZERO interest in making you reliant on us or on anyone for that matter. We want to empower you with the tools and knowledge hidden from you for centuries to bring your body back into balance and teach you how to keep your body in balance for as long as you choose to be in this corporeal body in this time-space. At Pura Vida Foodology Planet-*wide* we focus on, well, Foodology, the alchemy & science of making food your medicine. We utilizing holistic food based medicine to educate and guide you back into harmony with your higher self so your body can heal itself. My entire team and I get detailed in the defining experiences of your past and present including physical, emotional, physiological, nutritional and spiritual health, family health history, past health goals and future health goals.

Before we guide you with a Personalized Guidance Plan to bring your body back into balance

we want to learn all about you, otherwise, we're just speculating. I'm great at speculating. I have decades of experience to pull from and when it comes to *your body* we have zero interest in speculating, guessing or *practicing*. We're here to help and there are many paths that lead to the same place. Some are more or less effective, some are very costly, some include ingredients or parts or technology that are difficult to source, some are dangerous, most are ineffective because they are not a “Whole Treatment” and a simple internet search compiles thousands of doctors and specialists selling some *product* that promises everything. Did it work? Are you cured? Probably not or you wouldn't be here.

We give you the information we know works and has worked for thousands of years regardless of your gender, gender identity, ancestry, blood type, skin color, family history, health history, spiritual belief or age. Regardless of whether you are making it rain Benjamins like a rap video or are on an EBT budget. We even give you all the secrets to good health for a long and abundant life they don't want you to know because we believe it is criminal to keep them a secret. Yes, we sometimes recommend machines, modalities, treatments and / or supplements to help you reach your goals and see results faster. To be clear, you don't *need* them ***and*** they will help you reach your wellness goals faster like driving to the grocery will get you there faster than walking. Ultimately, you end up at the same destination. How fast you get there is up to you.

If any of our questions feel invasive, our intent is NEVER to make you feel defensive and ALWAYS to better guide you on *your* journey because this is about YOU. When we have all the data we're able to see patterns not all health and wellness professionals are trained to see. Maybe you've been diagnosed with a type of cancer but your PH is too high to form cancer cells or you've been diagnosed with a behavioral condition and we see a block(s) is your ducts and/or kidney, liver and gallbladder stones or you've been diagnosed with type II diabetes and we see PCOS or you've been diagnosed with PCOS and we see a severe gluten-intolerance. Cancer, mood swings, indigestion, stones, anger issues, high epithelial cells, chronic inflammation, low red or white cells, etc. are all SYMPTOMS and we treat CAUSES. When we treat CAUSES we eliminate SYMPTOMS and the more “Whole” Information we have the more effectively we can identify CAUSES. By “Whole Information” we mean information you might not think is related to what brings you to us today.

The more information we have, the better we are able to guide you with a mix of behavioral science, Foodology, alchemy, naturopathic, Ayurvedic and ancient Chinese medicine, physics, chemistry, bioelectric tuning, DNA repair, lymphatic cleaning, vibrational etymology, acoustic harmonics, vocal toning, word magic, seasonal biology, biology, botany, biodynamics, aquaponics, net-positive living and other proprietary healing modalities.

Some people have commented on the length and amount of detail in our New Client Form. Yep, that's true. It may be the most in-depth form you ever fill out that's all about *you*. We want the book. Don't worry, our follow-up forms are only two pages long. Our New Client Form is very detailed because our guidance, attention to detail and personal investment in *you* is very detailed. If the forms seems a little jumbled or out-of-order it is intentional. It is designed using various neurolinguistic techniques to illicit specific hormonal and neurochemical responses as you fill it out. This is with the intent to better help you reach your

specific health and wellness goals by helping to uncover patterns and behaviors you may not even by consciously aware of.

Remember, there are ZERO wrong answers except any answers you choose to withhold. We are ONLY interested in YOUR truth. Please be honest and detailed. We have ZERO interest in judging or reprimanding you for past choices. They are done and in the past. Let's move forward from here. We are only interested in the NOW and getting you the resources and **The Right Tools** your body needs to come back into balance and stay in balance for as long as you want to be here. We're here to lift you up not to tear you down.

May your life be full of great joy with the health and abundance to enjoy it,

Dr. Ava Perez

Pura Vida Foodology Planet-_wide_

Dr. AvatarNirvana Perez - *Foodologist* - NP MD PhD
ısenada | Mexico | Costa Rica | Hawaii | Bali | Indonesia | Philippines | Thailand | Africa | New Zealand

NEW CLIENT HEALTH FORM

NAME:_____ PREFERRED MONIKER:_____

DAY:_____ DATE:_____ YEAR:_____ DOB:_____ AGE:_____

ADDRESS:_____

CITY:_____ STATE:_____ ZIP CODE:_____

TELEPHONE:_____ EMAIL:_____

PREFERRED METHOD OF CONTACT: ☐ Phone ☐ Email ☐ Other:_____

GENDER:_____ GENDER IDENTITY:_____

.....

EMERGENCY CONTACT NAME:_____

PHONE NUMBER:_____ RELATIONSHIP:_____

EMERGENCY CONTACT NAME #2:_____

PHONE NUMBER:_____ RELATIONSHIP:_____

.....

OCCUPATION:_____ EMPLOYER:_____

AVG HRS WORKED PER WEEK:_____ DAILY TRANSPORTATION TIME:_____

METHOD OF TRANSPORTATION:_____

DESCRIBE WORKING ENVIRONMENT HEALTH (chemical exposure, safety, sound, light, pace, comfort, relationships, access to outdoors, etc):_____

_____

_____

.....

EDUCATION LEVEL:_____ AREAS OF INTEREST & CONTINUED STUDY:

_____

_____

.....

WHAT ARE YOUR HEALTH GOALS?_____

_____

_____

_____

_____

_____

_____

_____

drava@dravatarnirvana.com +52 646 211 3852 +1 619 392 1899 https://dravatarnirvana.com

Pura Vida Foodology Planet-*wide*

Dr. AvatarNirvana Perez - *Foodologist* - NP MD PhD
ısenada | Mexico | Costa Rica | Hawaii | Bali | Indonesia | Philippines | Thailand | Africa | New Zealand

WHAT BRINGS YOU TO US TODAY? (Include any recent accidents/injuries as well as any and all previous accidents/injuries, diseases, conditions, emotional resolve): _____

_____

_____

_____

_____

.....

WHO REFERRED YOU?_____

.....

ALLERGIES (Please list all allergies including medications, foods, metals, seasonal, etc):_____

_____

_____

.....

CURRENT HEIGHT: _____ CURRENT WEIGHT: _____ GOAL WEIGHT: _____

BLOOD PRESSURE: _____ /_____ ENERGY LEVEL RIGHT NOW: _____

.....

RATE YOUR OVERALL PAIN RIGHT NOW (Mark on scale of 1-10 or N/A if not applicable)

	N/A	Poor				Fine					Well
Physical Aches & Pains	□	1	2	3	4	5	6	7	8	9	10
Acute Pain	□	1	2	3	4	5	6	7	8	9	10
Chronic Pain	□	1	2	3	4	5	6	7	8	9	10
Anxiety	□	1	2	3	4	5	6	7	8	9	10
Emotional Stress	□	1	2	3	4	5	6	7	8	9	10

.....

MEDICATIONS Please list all medications, vitamins, minerals, tinctures, salves, sprays or herbal supplements, cannabis, CBD oil, etc. that you are taking, including the dose and for how long (Please include separate sheet if needed):_____

_____

_____

_____

_____

_____

_____

_____

Pura Vida Foodology Planet-*wide*

Dr. AvatarNirvana Perez - *Foodologist* - NP MD PhD

ısenada | Mexico | Costa Rica | Hawaii | Bali | Indonesia | Philippines | Thailand | Africa | New Zealand

MEDICAL HISTORY Please list all surgeries, diseases, ailments, conditions, treatments, vaccines, flu shots diagnosed, suspected and/or hereditary: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

.....

PAST & PRESENT ILLNESSES/CONDITIONS:

GASTROINTESTINAL	YES	PAST
Irritable bowel syndrome	□	□
GERD (reflux)	□	□
Crohn's disease/ulcerative colitis	□	□
Peptic ulcer disease	□	□
Gallstones	□	□
Other:	□	□

RESPITORY	YES	PAST
Bronchitis	□	□
Asthma	□	□
Emphysema	□	□
Pneumonia	□	□
Sinusitis	□	□
Sleep apnea	□	□
Other:	□	□

ENDOCRINE / METABOLIC	YES	PAST
Hyperthyroidism (overactive thyroid)	□	□
Polycystic Ovarian Syndrome	□	□
Infertility	□	□
Metabolic syndrome/insulin resistance	□	□
Easting disorder	□	□
Hypoglycemia	□	□
Other:	□	□

INFLAMMATORY / IMMUNE	YES	PAST
Rheumatoid arthritis	□	□
Chronic fatigue syndrome	□	□
Food allergies	□	□
Environmental allergies	□	□
Multiple chemical sensitives	□	□
Autoimmune disease	□	□

URINARY/GENITAL	YES	PAST
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐

ENDOCRINE/METABOLIC	YES	PAST
Celiac disease	☐	☐
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐

CARDIOVASCULAR	YES	PAST
Angina	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrhythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐

CANCER		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

MUSCULOSKELETAL	YES	PAST
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐

SKIN	YES	PAST
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐

NEUROLOGICAL/EMOTIONAL	YES	PAST
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐

NUTRITION AND DIET

1) Do you follow a specific diet plan (i.e. vegetarian, vegan, plant based, raw, Keto, low carb, high protein, pescatarian, blood type, low sodium, no dairy, gluten-free, no wheat, Foodology recipes, etc): _____

2) How do you feel after you eat? (energized, tired, bloated, hard abdomen, foggy, hot, abdominal cramping, gas, acid reflux, heart burn, inflammation, etc): _____

3) Do you avoid certain foods? And if so please explain why: _____

4) How many meals a day do you eat? _____

5) How many snacks and what snacks? _____

6) How often do you skip meals? _____

7) How frequently do you eat out? Where do you eat out and what do you typically order? _____

8) How often do you eat fast food? Where and what do you order? _____

9) Do you eat FAST or eat SLOW? Big bites or small bites? How many times do you chew?

10) Do you consume alcohol? If yes, how often and what kinds? _____

11) What is your comfort food? _____

12) What is your sad/stress food? _____

13) How often do you use food to manage stress? _____

14) How often do you cook? _____

15) What do you like to cook? _____

16) What is your cooking proficiency? _____

17) What is your relationship with food? Be specific: _____

18) What kind of relationship do you want to have with food? _____

19) What is the first thing you consume upon waking (water, coffee, kefir, juice, soda, peanut butter, crackers, milk, cereal, sausage, apple cider vinegar, etc): _____

20) Do you eat breakfast? □ Yes □ No | How many hours after waking? _____

If yes, please list all foods, condiments, beverages, supplements, medications, sprays, etc. consumed with breakfast: _____

21) If no, please let us know why you typically skip breakfast: _____

22) Do you eat lunch? □ Yes □ No | How many hours after breakfast? _____

If yes, list all foods, condiments, desserts, beverages, supplements, medications, sprays, etc. consumed with lunch: _____

_____

_____

23) If no, please let us know why you typically skip lunch: _____

_____

_____

_____

24) Do you typically have a snack between breakfast and lunch? ☐ Yes ☐ No

This includes coffee, tea, smoothie, donut, slice of watermelon, 5 almonds, etc. If yes, please list snacks you frequently consume: _____

_____

_____

_____

25) How many hours after breakfast do you crave a snack? _____

_____

_____

_____

26) If no, please let us know why you typically don't snack between breakfast and lunch: _____

_____

_____

_____

27) Do you eat dinner? ☐ Yes ☐ No | Do you typically have a snack between lunch and dinner?

☐ Yes ☐ No | This includes coffee, tea, smoothie, beer, kombucha, cocktail, donut, glass of wine, string cheese, carrot sticks, etc. If yes, please list snacks you frequently consume:

_____

_____

_____

_____

28) How many hours after lunch do you crave a snack? _____

_____

_____

29) If no, please let us know why you typically don't snack between lunch and dinner: _____

_____

_____

_____

_____

30) Do you typically have a late night snack? ☐ Yes ☐ No | If so what do you typically have for a late night snack? _____

_____

_____

_____

31) How many hours before bed do you eat? _____

_____

_____

32) What foods do you consider to be indulgences and rewards? _____

_____

_____

_____

_____

33) What foods do you consider necessary but unenjoyable? _____

_____

_____

34) How many servings per WEEK do you typically eat of these foods:

Fruits (not juice): _____
Vegetables (not including white potatoes): _____
Legumes (beans, peas, etc): _____
Nuts & Seeds: _____
Wheat Pasta: _____
Red Meat: _____
Healthy Fats (olive oil, coconut oil, etc): _____
Unhealthy Fats (vegetable oil, lard, margarine, etc): ___
Sweets (cookies, candy, cake, ice cream, etc): _____

Pork: _____
Fish: _____
Chicken/Turkey: _____
Wheat Pizza: _____
Sandwiches/Wraps (wheat): _____
Ultra Pasteurized Dairy: _____
Dairy Alternatives: _____
Soda (regular or diet): _____

35) Have you ever depended on food in a way that disrupted your life and relationships? _____

_____

_____

_____

36) Any other information about the food, diet, nutrition, cooking, and your relationship with food you want us to know: _____

_____

_____

BEVERAGES, COFFEE, TEA, SODA, JUICE, WATER, ETC.

1) Coffee: How many cups per day? How do you take your coffee? What kind of coffee i.e. toast, style, source, fair trade, grind your own, instant, Starbucks, etc: _____

_____

_____

_____

_____

2) What reaction do you have to caffeine i.e. perks you up, irritable, wired, exhausted, etc: _____

_____

_____

_____

3) Tea: Black, Green, White? How many cups per day? How do you take your tea? _____

_____

_____

4) Water: How many cups a day? _____
5) What kind? (i.e. bottled, BPA free, natural spring, primary water, charcoal filter, Brita filter, refrigerator filter, straw, terracotta egg, ozone filter, etc): _____

_____

_____

6) Soda: How many per day? What kinds of soda? Please include flavors as well as Brands:

_____

_____

_____

7) Any other information about fluids, hydration, water, and your relationship with water and fluids you want us to know: _____

_____

_____

_____

.....

HEALTH HISTORY

BIRTH & CHILDHOOD: (check all that apply)

You were born: ☐ Term ☐ Premature ☐ Don't know ☐ Natural ☐ Epidermal ☐ Hospital

☐ Home Birth ☐ Birthing Center ☐ Water birth ☐ Additional information about your birth: _____

_____

Please explain any pregnancy or birth complications: _____

_____

☐ Breast-Fed / How Long: _____ ☐ Bottle-fed / Type of Formula: _____ ☐ Don't know

Age Introduced To: Solid Food _____ Wheat _____ Dairy ____ Ultra Pasteurized Dairy _____

As a child what foods did you avoid and why (i.e. milk, dairy, wheat, peanuts, strawberries, etc): ____

_____

_____

DENTAL HISTORY (Please check that all that apply and how many)**:**

☐ Silver Mercury Fillings_____ ☐ Gold Fillings_____ ☐ Root Canals_____ ☐ Implants_____

☐ Cavities_____ ☐ Caps/Crowns_____ ☐ Tooth Pain_____ ☐ Bleeding Gums_____

☐ Gingivitis_____ ☐ Abscess_____ ☐ Problems Chewing_____ ☐ Extractions_____

☐ Broken Teeth_____ ☐ Chipped Teeth_____ ☐ Other Dental Concerns_____

Have you had any mercury fillings removed? ☐ Yes ☐ No If yes, when:_____

How many fillings did you have as a kid? _____

How often do you brush your teeth?_____ Floss? _____ Tongue Cleaning?_____

Oil Pulling?_____ Mouth Wash?_____ Type of Toothpaste:_____

Dental Goals: _____

_____

_____

_____

FAMILY HEALTH HISTORY (check all that apply)**:**

☐ Cancer ☐ Heart Disease ☐ Hypertension ☐ Obesity ☐ Diabetes ☐ Stroke

☐ Autoimmune Disease ☐ Arthritis ☐ Rheumatoid Arthritis ☐ Kidney Disease ☐ Thyroid Problems

☐ Seizure/Epilepsy ☐ Psychiatric Disorders ☐ Anxiety ☐ Depression ☐ Asthma ☐ Allergies

☐ Eczema ☐ ADHD ☐ Autism ☐ Irritable Bowel Syndrome ☐ Dementia ☐ Substance Abuse

☐ Genetic Disorders ☐ Other:_____

Details regarding family health history:_____

_____

_____

_____

ENVIRONMENTAL / DETOXIFICATION HISTORY

How do these affect you? Write N/A if not applicable

☐ Cigarette Smoke_____ ☐ Perfume/Colognes_____ ☐ Paint_____

☐ Cleaning Products_____ ☐ Auto Exhaust Fumes_____ ☐ Salon Fumes_____

☐ Other _____

At home and/or at work are you regularly exposed to any of the following (check all that apply):

☐ Mold ☐ Water Leaks ☐ Renovations ☐ Chemicals ☐ Electromagnetic Radiation ☐ Smokers

☐ Damp Environments ☐ Carpets or rugs ☐ Old Paint ☐ Stagnant or Stuffy Air ☐ Pesticides

☐ Herbicides ☐ Cleaning Chemicals ☐ Asbestos ☐ Airplane Travel ☐ Harsh Chemicals (solvents, glues, gas, acids, etc)_____ ☐ Heavy Metals (lead, mercury, aluminum, etc)_____

☐ Other_____

Have you had a significant exposure to any harmful chemicals? ☐ Yes ☐ No

If yes, Chemical Name, Date, Length of Exposure:_____

What kind of pets or farm animals do you have:_____

How Many?_____ Do they live: ☐ Inside ☐ Outside ☐ Both Inside & Outside

Sleeping/Resting Habits: ☐ Their Own Bed ☐ Sleep With You

Briefly describe your relationship with the animals in and at your living situation:_____

_____

_____

.....

GENERAL HEALTH INFORMATION

Do you smoke? ☐ Yes ☐ No How many packs per day: _____ How many years: _____

WHAT BRAND(S): _____

_____

What type i.e. cigarettes, cigars, pipe, e-cig, vape, etc: _____

_____

_____

_____

Have you attempted to quit? ☐ Yes ☐ No If YES, with what methods: _____

_____

_____

Are you interested in unlearning behaviors that harm you and learning / relearning positive behaviors to no longer feel the "need" for chemical dependence? ☐ Yes ☐ No

CURRENT WELLNESS THERAPIES (List any and all you have received as well any you are currently practicing i.e. massage, acupuncture, yoga, meditation, breathing, sun gazing, lymphatic massage, detoxing, prayer, singing, dancing, energy work, etc): _____

_____

_____

_____

_____

RECENT EVENTS (List any recent traumatic events i.e. job loss, divorce, death of a loved one, relocation, physical or mental harm, etc): _____

_____

_____

_____

_____

BURDENS (List any traumatic events from your entire life you are still overcoming)**:** _____

_____

_____

_____

_____

MAJOR STRESSORS (List your biggest stressors)**:** _____

_____

HOW YOU MANAGE YOUR STRESS: _____

_____

HOW YOU BLOW OFF STEAM: _____

_____

_____

_____

_____

_____

_____

LIST 3 THINGS YOU ARE MOST GRATEFUL FOR TODAY:

1) _____

_____

2) _____

_____

3) _____

HOW CURRENT HEALTH ISSUES AFFECT HOW YOU LIVE YOUR LIFE: _____

_____

_____

_____

_____

WHO DO YOU LIVE WITH? _____

_____

DESCRIBE YOUR HOME HEALTH ENVIRONMENT (Light, noise, dirty, dark, private, comfortable, safe, chemical exposure, relationships, children, parents, roommates, etc)**:** _____

_____

_____

_____

_____

DESCRIBE YOUR SUPPORT SYSTEM: _____

_____

SPIRITUAL/RELIGIOUS PRACTICES: _____

DO YOU EXERCISE? (List what kind(s), how often, where)**:** _____

WHAT ARE YOU MOST PASSIONATE ABOUT? _____

IF MONEY WAS NO OBJECT HOW DO YOU ENVISION USING YOUR TIME? _____

HOW MANY TIMES A DAY DO YOU POOP? (Tell us about your poops: how often, color, consistency, do they float or sink, chafing, yeast, aroma, etc): _____

HOW OFTEN DO YOU URINATE? (Color, amount, inflammation, discomfort, aroma, particulates, yeast, bacteria, how frequently do you hold your pee, type of urgency, etc): _____

_____

_____

TYPICAL RISING TIME: _____ **TYPICAL BED TIME:** _____

WAKING UP (Tell us how you feel first thing upon waking up: groggy, tired, slow, fatigued, moody, body aches and pains, anxiety, stiffness, alert, rested, ready to start the day, need coffee to brains, start with a workout, start with sex, etc)**:** _____

_____

_____

_____

_____

_____

SLEEP (Tell us how you sleep: i.e. fall asleep easily, insomnia, difficulty falling asleep, difficulty staying asleep, sleepwalking, sleep apnea, night terrors, night screaming, increased pain levels, frequent urination, restlessness, restless leg syndrome, night hunger, dehydration, racing mind, how many hours slept a night, if you get up in the middle of the night, falling back asleep, etc)**:**

_____

_____

_____

_____

.....

PHARMACOLOGY DEPENDENCY

1) Have you ever been in a rehab? ☐ Yes ☐ No
2) When and for what reason _____

   _____

   _____

   _____
3) How did you feel about your rehab experience and what did you get out of it? _____

   _____

   _____

   _____
4) Have you ever depended on alcohol in a way that disrupted your life and relationships? How?

   _____

5) How much alcohol consumption is normal and healthy _____

6) How much alcohol consumption is too much? _____

7) Have you ever depended on any prescribed pharmaceuticals in a way that disrupted your life and relationships? How? _____

8) Have you ever depended on any recreational substances i.e. meth, heroin, cocaine, crack, speed, angel dust, etc. in a way that disrupted your life and relationships? How? _____

HOW DEDICATED ARE YOU TO ACHIEVING YOUR HEALTH GOALS? _____

WHAT OTHER INFORMATION WOULD YOU LIKE US TO KNOW: _____

EYES: Please provide 2 photos of each eye and label them: left eye1, left eye2, right eye1, right eye2 totaling 4 photos with your completed *New Client Form*. Ensure all 4 photos are clear and in high resolution.

To obtain the clearest photos please use a tripod or enlist the help of a family member or friend or stranger at the bus stop. You are smart and creative.

BLOOD WORK & URINE ANALYSIS: Please provide complete lab results from your Pura Vida Blood Work & Urine Request with your completed *New Client Form*.

Pura Vida Blood Work and Urine Request Forms are attached at the end of this document. To complete the Pura Vida Blood Work and Urine Request you can request your primary care physician order these labs for you through your health insurance OR in Mexico you can get same day or next day lab results at any private laboratory. My team and I recommend Salud Digna in Mexico which has over 1,000 locations, costs around $110-$150 usd for everything on our Pura Vida Blood Work and Urine Request as well as same day or next day results and professional staff all without an appointment.

PRIOR TO YOUR CONSULTATION WITH THE DOCTOR

Email Dr. Ava your completed *New Client Form*, the complete lab results for your Blood Work and Urine Request as well as 2 clear photos of each Eye 1 week prior to your first consultation so I have time to study your health background, present concerns, lab & urine results and photos of your eyes so we can maximize the limited amount of time we have to best help you on your wellness journey.

May your life be full of great joy with the health and abundance to enjoy it.

Dr. Ava Perez

